Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 01/14/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Limited
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
Percent of indicators rated Failed:0.00%

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Marcia Tavares, Lead Reviewer and Consultant, Forefront LLC

Tom Popadak, Statewide Trainer, Florida Network of Youth and Family Services

Bill Mann, Chief Operating Officer, Florida Keys Children's Services

Persons Interviewed

- [x] Program Director
- [x] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

2 Case Managers
1 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
2 Program Supervisors
2 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [ ] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [ ] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

2 Health Records
3 MH/SA Records
13 Personnel Records
12 Training Records/CORE
5 Youth Records (Closed)
13 Youth Records (Open)
0 Other

Surveys

3 Youth | 4 Direct Care Staff | 0 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Program Activities
- [x] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [ ] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [x] Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.
Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Children's Home Society (CHS) is a statewide agency that employs more than 1,800 employees who are located in 15 divisions throughout the state. Since 1982, CHS of Florida has continuously maintained accreditation through the Council on Accreditation. The agency is headquartered in Winter Park, Florida and serves over 100,000 kids and family members each year.

Children's Home Society of Florida, Safe Harbor Shelter, is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. The 10 bed shelter facility is located on a large campus that also houses the agency's administrative offices and is the site of the Children In Need of Services/Families In Need of Services (CINS/FINS) program which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in South Palm Beach County. Services are provided to male and female youth between the ages of ten and seventeen. The program continues to demonstrate its commitment by providing a plethora of services to youth in the CINS/FINS program and offers life skills training, educational and career coaching, guidance, and safe housing so teens can learn self-sufficiency as they transition into adulthood and pursue opportunities for life success. Each year, more than 7,000 teens and young adults benefit from these program offerings.

Since the last onsite QI review, CHS Safe Harbor has received additional funding for its Street Outreach Program through the Department of Human Services, Administration for Children and Youth. The funding allows the provider to reach youth who are at greatest risk of homelessness and delinquency through the provision of residential shelter and family therapy. The program was funded for three years and began in October, 2013.

The youth at CHS Safe Harbor have been able to gain valuable career skills and career development with the assistance of a Job Coach. Select youth are involved in the “Teach-A-Teen” program that provides an opportunity for youth to interact with business owners in the community who serve as mentors and provide youth with necessary employment and job skills training. The youth work with a Job Coach during their time at Safe Harbor and upon discharge from the shelter, the youth and their family are offered non-residential services. Additionally, the program provides structured enrichment activities for the youth such as: drug prevention; yoga; drama; broadcasting; pet therapy; and a tennis clinic. The shelter facility utilizes space to support these activities for the youth and has designated rooms for art therapy and an indoor game room where youth are encouraged to earn privileges to play video games. The art education program is supported by a grant which has been used to purchase art supplies for the youth to use in art therapy.

The program also continues to leverage its relationship with the local schools and participates in meetings hosted by the school guidance counselors. The meetings are held separately for elementary, middle, and high school guidance counselors and increases knowledge of the CINS/FINS program as well as facilitate the referral process. In addition, Safe Harbor has continued to foster a positive partnership with the School District of Palm Beach County and was chosen by the Guidance Counselors as the recipient of clothing donations which has allowed the program to expand its clothing closet into a clothing room.

Standard 1: Management Accountability

Overview

Narrative

CHS Safe Harbor is under the leadership of a management team consisting of an Executive Director, a Director of Program Operations, a Clinical Supervisor, a Residential Program Manager, a Data Management Supervisor, and an Adminstrative Secretary. In addition to the Residential Program Manager, the residential component of the program is staffed by a Residential Shift Leader, ten (10) fulltime Youth Care Workers (YCW), and five (5) Relief YCWs. The program is operated around three ten-hour shifts that provide two hours overlap for shift exchange. The shift times are: 6 a.m. to 4 p.m., 2 p.m. to 12 a.m., and 10 p.m. to 8 a.m. Both the Director of Program Operations and the Residential Program Manager are new to their positions and are in their first year of working in the CINS/FINS Program.

The agency's Clinical Supervisor is a licensed mental health professional who oversees the agencies counseling services.The clinical component of the program includes three (3) Non-Residential Counselors (one RIMH, one MSW, and one Bachelor's level Counselor II position) and one Masters level Residential Counselor. The program also utilized the services of five volunteers, one of whom started after the last onsite QI visit in February 2013. There were no vacant positions in the program at the time of the visit.

1.01 Background Screening

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The policy requires all staff and volunteers to complete a Level 2 Background Screening that includes good moral character documentation, employment history checks, employment screening, criminal record checks, and juvenile record checks. Additionally, the provider conducts a background check with the Department of Motor Vehicles prior to hiring an employee.

A total of fourteen (14) applicable personnel files were reviewed for eleven new hires, two 5-year re-screened staff, and one volunteer. Nine of the eleven staff who were hired since the last onsite QI visit received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire.

During the review period, the program had one new intern. The intern's DJJ background screening result was received prior to the volunteer's start date with the agency.

The provider had one current staff and a recently terminated staff who were eligible for the 5-year re-screening during the review period. The current employee's anniversary date was 5/18/2013 but the re-screening was not submitted until 1/6/14 and, as of the date of the onsite visit, was not yet completed due to rejected fingerprints. The terminated staff's re-screening was due on 4/22/13 but the staff had not been re-screened as of the termination date of 1/3/14. This oversight was discovered by the Employee Relations Manager during an internal audit. It was noted that the staff had not worked since August 2013 and was terminated on 1/3/14. A CCC report was submitted to DJJ for the missed 5-year rescreening for the terminated staff but the report was not accepted. A revised corporate policy regarding 5-year rescreening was implemented by the provider to address this issue.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted timely to the DJJ Background Screening Unit on November 6, 2013.

The provider failed to meet the Department's background screening requirement for two new hires and two eligible five-year rscreenings. Two new staff were hired by the provider prior to the agency's receipt of their eligible DJJ Background Screening results. One of the staff is a Residential Program Manager and the other staff is an Administrative Secretary. The screening results were received three months past the Residential Manager's hire date and one month later for the Administrative Secretary. In addition, per the provider's policy, the HR Department will review all eligible 5-year re-screenings in January each year and initiate the re-screening process in the applicable month. This was not evident in two applicable 5-year re-screenings in that the re-screenings were not completed by the employees' five-year anniversary dates.

The program has a policy and procedure detailing the availability of centralized intake services twenty four hours a day, seven days a week which includes emergency intake and referrals. Youth and parents/guardians sign forms stating they have received available service options, rights and responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake. Three nonresidential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received; available service options, rights and responsibilities of youth and parents/guardians, a consumer handbook, the CINS/FINS brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake. These forms were also available in Spanish versions for those clients that were not fluent in English. Three residential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received; available service options, rights and responsibilities of youth and parents/guardians, the brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a current policy and procedure in place for the provision of an abuse free environment. The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are posted at various locations throughout the facility. Youth are also informed of these procedures during program orientation and the number is included in the Resident Handbook. The program also has a grievance box and forms accessible to youth in the dormitory lounge near the staff desk. Upon hire, employees receive and sign receipt of the Agency's Code of Conduct which outlines the agency's policy against workplace violence and expectation regarding the provision of a safe environment. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report.

A review of three grievances during the review period showed allegations against staff for physical threat, sexual abuse, and verbal discrimination. Two of the grievances were resolved after interviewing and speaking with staff. The Relief Staff was placed on administrative leave due to the incident of alleged sexual abuse; however, the investigation was closed by CPI and was determined to be unfounded. No incidence of youth being deprived of basic needs or physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit.

Abuse reporting was evident and the program maintains a log of calls that are made to the abuse hotline in the Incident Report binder. The abuse report is entered in the providers AirsWeb incident reporting database. Fourteen of these incidents were reviewed during onsite visit for the review period and copies of the incidents reported are on file.

The three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. The three youth surveyed also indicated that they feel safe in the program and have never heard staff threaten them or other youth. The four staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair and/or good at the program.

All of the staff training files that were reviewed documented staff training in Child Abuse Reporting.

The resolution phase of two of the grievances were not signed by the staff or by the youth on one of the grievances reviewed. Similarly, the resolution was not indicated (Yes or No) on one grievance. Ensure that the acceptance of the resolution to grievances are signed by the youth and staff.

One of the three youth surveys indicated that staff is not always respectable towards youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written incident reporting policy. The agency's policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident.

The agency had a total of twenty (20) reportable CCC incidents over the last six (6) months. Copies of the DJJ CCC reports were provided by the DJJ Contract Manager for the Office of Prevention and Victim Services for the review. Additionally, a review of the agency's incidents reported to CCC was conducted and was compared to the reports from DJJ. Of the 20 incidents reviewed, 3 were absconds, 11 were contraband, 1 was youth behavior/program disruption, 1 was employment prior to background screening, 3 were alleged sexual abuse (1 staff, 2 youth on youth), and 1 was a medication error. All of the 20 incidents were reported within the DJJ CCC 2-hour reporting time frame.

The program documents reportable incidents in AirsWeb, an incident reporting database, and copies are maintained in a separate binder and also documented on a log. Only one of the twenty incidents reviewed was not entered into the provider's Airs Web Incident Reporting system; however, the incident was reported to CCC on time and was documented in the program logbook. The AirsWeb entry was rectified during the onsite visit.

The reviewer observed a higher frequency of contraband as compared to the other types of incidents that were reported. These items were discovered by staff during room search and the concern is a CQI issue that has been identified by management and is being addressed by the CQI team.

No exceptions noted

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy and procedure in place that ensures that all direct care staff is appropriately trained within the first year of hire to adequately meet the needs of the sheltered youth. The shelter also has a policy and procedure that ensures all direct care staff is appropriately trained on an ongoing basis. A copy of the provider's Training Plan for FY 2013-2014 was submitted to the Florida Network on September 15, 2013.

The training files for three (3) First Year staff were reviewed. Two of three staff exceeded the standard requirement for 80 hours of training and the third staff is on target for meeting the requirement. Orientation training was listed as completed on the training log but was not documented on the Program Orientation training form for one employee and was not signed and/or dated by the employee and supervisor. Consequently, there is no evidence for completion of CINS Core, Signs and Symptoms of Mental Health and Substance Abuse, and Title IVE training for this employee. Two of the three first year staff did not receive Fire Safety training within the first 90 days per the provider's policy. Additionally, one staff did not complete the CPR training within the agency's 180-day requirement.

Three (3) in-service staff files were reviewed. Two (2) of the three files reviewed at the time of the onsite visit were behind on training; one had 20 hours remaining with two months left in the current training year and the other staff had 15 hours remaining with one month to complete them. None of the three in-service staff have completed the required Fire Safety training to date but

still has time to complete the training prior to the end of their training year. All three staff had current CPR/First Aid certification in their training files at the time of the visit.

The training hours are listed on a training log form, which documents the training topic, date of training, number of hours of the training, renewal date, and cumulative total. In addition, each training file includes a training needs assessment form that shows the training that is required each year.

Completion of orientation training, including some of the required core topics, was not evident for one new hire. Two of the three first year staff did not receive Fire Safety training within the first 90 days per the provider's policy. Additionally, one staff did not complete the CPR training within the agency's 180-day requirement. Two (2) of the three files reviewed at the time of the onsite visit were not on target for completing the 40 hours of training required. Also, none of the three inservice staff have completed Fire Safety training to date but has time to complete the training. During the onsite visit, the provider scheduled all of the employees in need of the Fire Safety training were scheduled to complete the training by 1/17/2014.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive CHS Quality Management Plan for the current FY 2013 that is comprised of three sections. Section 1 describes the agency's philosophy, Quality Management Structure, CQI strategies, and stakeholders. Section II includes a description of the agency's long-term strategic goals and objectives, management/operational performance, and program results/outcomes. Section III provides procedures for data collection, aggregation of review and analysis, communicating results, using data for implementing improvement, and assessment of the effectiveness of the QM process.

The program has a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due by the 25th day of the 2nd month of each quarter. A separate case record review is also conducted by the youth care staff. Upon completion of each record review, the QMS aggregates the results and provides a copy of the aggregated report and Quality Management Division Evaluation to the Quality Improvement Review program supervisor to discuss themes, trends, and any areas of concern. Program supervisors ensure appropriated follow-up is taken by their staff and responded to in a timely manner. The QMS also follows-up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee, represented by the Shelter Manager and non-residential staff, is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management on a monthly basis. Each program and site has a representative who sits on the Safety Committee. The safety committee meets on the third Thursday of each month and if unable to attend, can appear by phone. The QM facilitates the call and meeting minutes from each meeting are produced and provided to committee members (including the QMS), Program Managers, and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted by program supervisors and reported to the QMS on a monthly basis via the PPR.

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. A copy of the most recent Consumer Satisfaction Survey Result for the 1st period of FY 2013-2014 was reviewed.

The provider also has a CINS/FINS Analyzing and Reporting Workgroup comprised of the Director of Program Operations (DPO), Program Manager, Clinical Supervisor, QMS, and Data Specialist that meets monthly, on the third Friday, to review findings of the peer reviews, incidents/accidents, satisfaction survey results, outcome data, and Netmis data reports. A walkthrough of the facility is conducted to review key program requirements in the shelter prior to the meeting. Strengths, weaknesses, and goals are reviewed and documented in the minutes. Copies are provided to the Youth Care Workers and Counselors.

Outcome data is reviewed monthly, quarterly, and annually. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. The outcomes data incorporates all of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. A copy of the Florida Network Agency Contract Benchmarks, July 1- December 31, 2013 was reviewed on site.

No exceptions noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

CHS Safe Harbor provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a psychosocial assessment, and a service plan. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed. The shelter program provides critical temporary shelter care services to run-away and homeless youth, and takes care of their basic needs with the ultimate goal to reunite the youth with their families. The facility has eight beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, CHS Safe Harbor coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

Non-residential counseling services are provided by qualified Master's and Bachelor's degree staff who are under the supervision of a licensed Clinical Supervisor. Case file review revealed that the counselors monitor the youth's and family's progress in services, provided support for the families, and monitored out-of-home placement as applicable. Additionally, the program has many outside agencies with which to refer youth and families and makes multiple referrals to meet the needs of the families it serves.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure detailing the availability of centralized intake services, twenty four hours a day, seven days a week, which includes emergency intake and referrals. Youth and parents/guardians sign forms stating they have received available service options, rights and responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

Three nonresidential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received: available service options, rights and responsibilities of youth and parents/guardians, a consumer handbook, the CINS/FINS brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake. These forms were also available in Spanish versions for those clients that were not fluent in English.

Three residential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received: available service options, rights and responsibilities of youth and parents/guardians, the brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy stating the Psychosocial Assessment is initiated within 72 hours of admission if the youth is in shelter care or updated if most recent psychosocial is over six months old; or completed within three face-to-face contacts following the initial intake if the youth is receiving non-residential services or updated if most recent psychosocial is over six months old.

Three nonresidential files were reviewed. All three had the Psychosocial Assessments completed within three face to face contacts and all three were completed by at least a bachelor's level staff and contained a supervisor's signature for review. One of the files had youth identified with an elevated risk of suicide and a further assessment of risk suicide was conducted by a Master's level counselor under the direct supervision of a licensed mental health professional.

Three residential files were reviewed. All three had the Psychosocial Assessments initiated within 72 hours of submission and all three were completed by at least a Bachelor's level staff and contained a supervisor's signature for review. Two of the files had youth identified with an elevated risk of suicide and both had further assessment of risk suicide conducted by a Masters level counselor under the supervision of a licensed mental health professional.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy stating a service plan is developed with the youth and family within seven working days following completion of the Psychosocial Assessment and details what is to be contained in a service plan and that the plan is reviewed every 30 days.

Three Nonresidential youth files where reviewed. All were developed with the youth and family within seven working days following completion of the assessment. All plans contained identified needs and goals; type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates as appropriate; date the plan was initiated; and signatures of youth, parent/guardian, counselor, and supervisor. When the parent was not available or contacted via phone it was properly documented on the service plan.

Three residential youth files where reviewed. All three were developed with the youth and family within seven working days following completion of the assessment. All plans contained Identified needs and goals; type, frequency, location of services; persons responsible; target dates for completion; actual completion dates as appropriate; date the plan was initiated; and signatures of youth, parent/guardian, counselor, and supervisor, with the exception of one goal in one file which did not contain target date, frequency, location, or person responsible and one goal in another file did not contain the person responsible. When the parent was not available in person the plan was reviewed with them via a phone call as documented in the case file. All three youth interviewed were able to report goals that they were working towards during the youth interviews.

Exception:

One residential case file did not include target date, frequency, location, or person responsible for one goal (#8) in service plan.

One residential file did not have person responsible for one goal (#5).

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has polices relating to family involvement referrals to outside agencies, recommending and pursuing judicial intervention in selected cases, and youth discharge.

Three nonresidential Youth files were reviewed. All files had coordinated service plans implemented and a plethora of progress notes which reflected that the counselors monitored youth's and family's progress in services, provided support for families, and monitored out-of-home placement as applicable. The program has many outside agencies with which to refer youth and families. The program makes multiple referrals and tracks them at least monthly on their service plan and referral checklist as well as in their progress notes and on service plans. The program provided case monitoring and review of case staffings in the file that was applicable. The program also provides follow-up services after discharge.

Three residential Youth files were reviewed. Similarly, all files had coordinated service plans implemented, a plethora of progress notes that reflected the counselors monitored youth's and family's progress in services, provided support for families, and monitored out-of-home placement. The program has many outside agencies with which to refer youth and families. The program makes multiple referrals and tracks them at least monthly on their service plan and referral checklist as well as in their progress notes and on service plans. The program also provides follow provides services after discharge.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy to provide and array of services to preserve the unity and integrity of the family. The policy also includes supervisory review. In addition the program has a staff directive that further defines required timelines for supervisory review.

Three nonresidential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were maintained in all files. All files contained signatures of supervisory review by a LMHC.

Three residential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were well documented and maintained in all files. All files contained signatures of supervisory review by a licensed clinician.

All three youth interviewed reported they knew who their counselor was during the youth interviews and that their counselors asked them what they thought about and what they wanted to do while they were in shelter. In addition the residential shelter provides a plethora of groups above and beyond the five required weekly.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy detailing the CINS/FINS petition process including the case staffing committee. This includes that a case staffing committee is convened within seven 7 working days from receipt of the written request from the parent/guardian, and within 7 seven working days of the meeting, a written report is provided to the parent/guardian outlining the committee recommendations. The service plan review and revision policy and the CINS/FINS services policy state recommendations of the case staffing committee will be incorporated into the service plan.

Three nonresidential youth files were reviewed. In all cases proper notification was given to the family as well as the case staffing team. Representatives included school personnel, CINS/FINS provider, law enforcement, and the parents/guardians. The family was provided a written report outlining the committee recommendations in all cases. The program does have an established case staffing committee as well as an internal procedure for scheduling case staffing meetings as needed.

In one case, although a service plan review was completed 15 days after the case staffing, it was at a regular review time and did not incorporate new recommendations made by the case staffing committee but only contained a general statement that case staffing goals would be incorporated.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a policy detailing the confidential nature of case files. It specifies how cases are opened, how they are closed, were they are kept and how they are stored, whose responsibility it is to keep the files maintained, how they are organized, that they will be marked confidential, and how long they are kept for.

Three nonresidential files were reviewed. All three files were marked “confidential” and files are kept in a secure room. All three file records were organized in a neat and orderly manner so that staff can quickly and easily access information.

Three residential files were reviewed. All three files were marked “confidential” and files are kept in a secure room. All three file records were organized in a neat and orderly manner so that staff can quickly and easily access information. All three files were marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

CHS Safe Harbor Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with one dormitory for youth of both genders. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with two beds with separate pillows and bed covering and a closet for youth belongings. Youth have access to a large yard with tennis and basketball courts for outdoor activities.

All youth who are admitted to the program receive a copy of the Consumer Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group and family counseling, as needed. Group sessions are scheduled more than five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services. The program also has a Licensed Mental Health Counselor (LMHC) who serves as the Clinical Supervisor for four counselors and program interns. At least one of the counselors is assigned to the residential youth.

The shelter is designated by the Florida Network to provide staff secure services but has not admitted a Staff Secure youth since the last onsite visit. At the time of review, the current client census showed a total of eight (8) active youth in the residential program. The Department of Children and Families has licensed Safe Harbor as a Child Caring Agency, with the current license for ten (10) beds, effective until January 23, 2014. A relicensing visit was conducted and the provider met the criteria for re-licensing.

The program exceeds the requirement of quarterly emergency drills by conducting them three times monthly once on each shift. The agency also exceeds the group counseling requirements by often conducting groups more than once per day.

Counseling services to youth in the Residential program are provided by a Master's level Counselor under the supervision of a licensed Mental Health Supervisor. College Interns are also utilized by the program to assist with delivery of services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

An extensive inspection of the shelter environment was conducted during our tour of the facility. In general, it was noted by all of the review team members that the facility was clean, secure, and well maintained. There is a large area for recreation with a basketball court, a tennis court and a gazebo. The grounds are attractively landscaped and well maintained. There facility was free from any observable physical property damage and there was no graffiti, hazards or debris observed during our site visit.

The shelter is licensed by DCF as a 10 bed facility. The current license expires 1/23/14. The DCF licensing visit was held last week and the agency met all criteria for re-licensure, so they are awaiting their new license to be issued by DCF next week.

The kitchen and dining area were also inspected during this site visit and met all requirements for health and sanitation from the specific standards applied by the Department of Health during their annual inspections. The most recent inspection was conducted on 1/23/13 and no violations were noted on the inspection report. All food storage was in compliance with industry standards and CQI requirements (open food labeled, dated, correct temps). Menus are posted in the kitchen and approved and signed by a licensed dietician.

The annual fire inspection was conducted by Palm Beach County Fire Rescue office on 2/1/13. The kitchen exhaust hood was cleaned by Sanitation Services on 11/5/13 and is scheduled for the next six month cleaning in April of 2014. The overhead fire suppression system located in the kitchen above the stove was last serviced on 8/1/13 by Gold Coast Fire Equipment. Pest control services are provided by Gentle touch Pest Solutions, Inc.

The facility is equipped with a video surveillance security system that has 16 cameras that monitor both the interior and exterior of the shelter. During our site visit we also inspected or observed the laundry room, chemical storage, sharps storage, medication storage, an art room and a donation room filled with clothing and other items for residents in need.

An interview with the Program Manager confirmed the above policies, procedures and practices are in place and are consistently followed by the agency's employees.

No exceptions were noted during this CQI site visit.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

Youth admitted to the shelter go through a comprehensive new client orientation process that consists of 23 specific areas and is documented in the youth's client case file on the Client Orientation check List. Both the youth and the staff conducting the intake initial all 23 items on the checklist and sign and date the form at the bottom of the page.

During the orientation process youth are also provided a copy of the "Resident Handbook" that outlines and describes program services, rules, rights and responsibilities, confidentiality, grievance procedures and behavior management policies.

A total of six client case files (3 open, 3 closed) were reviewed for this indicator. This review revealed that in each of the six cases a client orientation was completed and documented. In addition, each of the 6 files reviewed also contained a signature page for the CHS Consumer Handbook and Safe Harbor Resident Handbook.

No exceptions were noted at the time of this QI review.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

The program is licensed by DCF for 10 youth. The facility has five bedrooms with two beds each and each room has an assigned number and the beds are identified by letter (A/B). At intake each youth is screened for various personal attributes and behavioral risk factors to determine an appropriate room assignment.

Room assignment criteria are listed and documented in each client case file on page two of the CINS Intake Form. Age, gender, height, weight, physical size/build and behavioral indicators such as history of aggression are all assessed prior to room assignment.

A review of 6 client case files indicated that each youth was assessed and assigned to a specific room and bed upon admission to the facility. An interview with one youth, one program manager and one youth care staff member also confirmed this practice to ensure that it was consistent with agency policy.

No exceptions were noted during this QI site visit.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

The program maintains a professional log book for staff to document the daily program activities at the Safe Harbor shelter. During this QI site review, an extensive evaluation of the program's current log book over a three month period was conducted.

All entries are written in ink, are legible, and signed by the staff entering the documentation. Log book entries that are considered to be of high importance such as intakes, discharges, appointments, behavioral concerns and incidents are highlighted. Errors are corrected with a single strike through and initialed by the staff member.

The shelter manager reviews the log on a regular basis (almost daily) and makes at least one weekly entry using red ink so they are easily identified by staff reviewing the log book. All staff are required to read the log book upon arriving to work and document this review by making an entry in the log. It was clear during this review that the shelter manager uses the log book effectively to educate, inform and supervise shelter staff.

There were no exceptions noted during this QI site visit.

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

The program has a behavior management system in place to provide positive incentives and negative consequences for appropriate and inappropriate behavior demonstrated by youth at the shelter. The system is based on a point and level system where youth who display positive behaviors earn points toward various rewards and privileges.

There are three levels in the CHS Safe Harbor behavior management system: Levels 1, 2, and 3. Youth are entitled to earn up to 38 points per day and a maximum of 266 points a week. Points can be cashed in at the "Shelter Store" where youth can purchase various items with their accumulated points for the week. The point store is located in the hallway across from the game room.

The behavior management system is explained to youth during the program orientation process and is also described in the Safe Harbor Shelter Resident Handbook that is given to youth at intake. An interview with the Program Manager and one youth confirmed that the behavior management system is in place and is consistent with agency policy.

No exceptions were identified during this QI site visit.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

At the time of this QI review the shelter was fully staffed and there were no vacancies. According to documentation provided by the agency, the program has 15 youth care staff assigned to the shelter program. There are 10 full time staff and 5 part time staff.

The Shelter Manager produces and posts the weekly staff schedule in the staff office in the shelter where the camera monitoring system is located. There are two staff, one male and one female, scheduled on each shift to maintain a ratio of 1 staff for every 5 youth which exceeds the 1:6 and 1:12 ratio required.

A review of staff schedules over the last three months indicated that the staffing patterns are consistent and stable in terms of the ratio (1:5) and the gender of staff (M/F) that are assigned to work each shift. Upon interview the Program Manager confirmed the practices related to staff scheduling are consistent with agency policy and CINS/FINS program requirements.

There were no exceptions noted during this QI review.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

During the last 6 months the program has served approximately 25 youth under the Domestic Violence Respite (DVR) Program. Most youth who meet eligibility criteria for this program are admitted as DVR clients for a 3 day period and then are automatically transitioned into CINS/FINS program services.

A review of 4 DVR case files (3 closed, 1 open) evidenced that all met the criteria for admission (arrest and referral from JAC), all stayed less than the 14 day maximum (most were in DVR for 3 days), all transitioned seamlessly into CINS/FINS services and all had service plans that addressed the reason for the DV referral (anger management, family communication).

The program is contracted to provide staff secure shelter at this site. There is a policy in place (CHS/7307) to address the requirements of this CQI indicator; however, they have not had a Staff Secure Shelter youth court ordered to the facility in over one year.

At the time of this review the agency had not yet developed a separate written policy to apply to the DVR program. However, during our site visit the agency Executive Director developed, approved and signed a new DVR policy effective 1/15/14.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

CHS Safe Harbor has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, YCW staff will interview youth and complete the intake. An initial intake assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Program Manager, Counselor and/or the DPO is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that is mounted in the medication room, on a youth alert form, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. Medication records for each youth are maintained in a binder that is stored in a locked medication cart in a locked room.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

The staff completing the intake completes the CINS Intake Form that documents any current medical conditions, medication, allergies, illnesses or injuries. The staff also completes a body chart that identifies and body markings, tattoos or scars. Medication verification form is also completed if the youth is currently taking any prescribed medications.

A review of six client case files (3 open, 3 closed) evidenced that in each case a healthcare admission screening was completed utilizing the CINS Intake Form, the body chart, and the prescription medication verification form (when indicated).

Of the files reviewed, three of the six had an existing medical condition and/or were taking medications. All three cases had the proper documentation and medical/mental health alerts placed in their files and on the magnetic board in the medication room at the facility.

There was one exception noted during this CQI review involving a medical condition and medical follow-up with a parent. One youth, who was admitted on 12/27/13, reported at intake that she had asthma and had been prescribed an inhaler but did not have it with her at the time of the admission to the shelter. The staff conducting the intake documented this on the CINS Intake Form and also documented several follow-up contacts with the youth's mother. The mother told the staff member that she would contact the doctors regarding the prescription for the inhaler.

The assigned counselor also had documented several contacts with the mother. However, two weeks have now passed without evidence that the situation was addressed and/or resolved at the time of this review. The counselor documented contact with mother on 1/9/14 and stated that the doctor's appointment was now scheduled for 1/21/14.

Upon interview, the lead youth care worker stated that the medical condition was not acute or chronic and that the client had not experienced any signs or symptoms of asthma during her placement at the shelter. The staff reported that the client also suffers from gastritis and was transported to the hospital in an ambulance on 1/9/14.

A letter from the Doctor's office was provided at the conclusion of this review stating that the asthma condition no longer requires medical supervision or medication (inhaler).

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure (CHS 7403) that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director. The policy was approved by the Florida Network in June of 2011.

During this QI site visit a review of 3 client case files (2 residential, 1 Non-Residential) was conducted to determine agency practices related to suicide risk assessment and prevention. The suicide risk screening was conducted in all cases utilizing the CINS/FINS Intake Form. The results of the screenings were reviewed and signed off on by a supervisor.

In the two residential cases, the youth were placed on sight and sound supervision until a suicide assessment was completed by the assigned counselor or the licensed mental health profession. In both residential cases the assessments were completed within 24 hours of admission. In the non-residential case the assessment was completed immediately by the assigned counselor under the direct supervision of the licensed Mental Health professional.

In all three cases it was determined that the youth was not currently at risk of suicide. However, the agency did follow-up and even though the youth were not in imminent danger of suicide they

requested that the youth sign a Safety Agreement for suicide prevention.

A review of incident reports did indicate that, on several occasions, youth who made threats of suicide or statements of suicide they were Baker Acted by law enforcement.

A knife for life and wire cutters are located in a wall mounted box in the youth care staff office for suicide emergencies. Staff are trained in suicide prevention and conduct emergency drills to prepare for these possible scenarios.

There were no exceptions identified during this QI review.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains written policies and procedures that are consistent with the QI Indicator and address the safe and secure storage, access, inventory, disposal and administration/distribution of medications. The program's policies and procedures include all the mandatory components required by the standard.

Medications were found to be stored in a locked medication room inside a locked medication cart, which is inaccessible to youth. The cart has separate drawer storage for injectable, oral, and topical medication. Each youth's medication is stored inside a zip-locked bag with a picture of the youth inside the bag. No controlled narcotics were currently prescribed for any of the youth in shelter at the time of this review but the practice for storage of same was inspected and met the requirement for the indicator. The practice for refrigerated medication demonstrated that such medications are kept in a locked refrigerator in a locked staff room next to the medication room. This room is accessible only to staff.

At the time of review, the program did not have a written list of staff who are designated to distribute and have access to medication. However, staff approved to distribute medication is designated on the staff schedule with the letter 'M'. A written list of approved staff was developed and submitted to the reviewer during the visit.

Medication counts are conducted perpetually, at the time of distribution, with running balances. In addition to perpetual counts, staff reviews the inventory on a shift-to-shift basis at shift change and date/sign the Shift Change Medication Count Log. Any discrepancy in the count is documented on the shift change count log. The medication inventory counts were verified during the visit.

Over the counter (OTC) medications are stored in the medication cabinet and are inventoried weekly by the Youth Care Supervisor and counted perpetually. The provider has only three OTC medications: Tylenol, Midol, and Pepto-Bismol. Each OTC has a separate count sheet.

Sharps were observed to be secured with inventory counts conducted weekly without exception. No syringes were being utilized onsite during the visit. The sharp counts were reviewed and were found to be accurate.

Medication Distribution Records included the required identification components including youth name, photo, allergies, precautions and information about the possible side effects of each medication. The full name of each youth is printed on the medication distribution log and the youth sign their initials to acknowledge receipt of each dosage of medication. However, the youth signature does not appear anywhere on the medication distribution log or records. Staff also initials distribution of the medication and a separate page shows the staff's printed name, signature, and title.

All three direct staff surveyed indicated that they assist youth in the delivery of medication and all three staff are included on the written list of staff with access to medications. Of the three (3) staff surveyed regarding knowledge about medication side effects, three (3) indicated shift change, alert form/log, and census board, two (2) indicated Physician's Desk Reference and staff meetings, while one (1) indicated med book. All three staff indicated that the process for communicating information was "very good".

One exception is that at the time of review, the program did not have a written list of staff who are designated to have access to and distribute medication. A list was developed and submitted to the reviewer during the visit.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

The system consists seven colors that reflect various different safety and supervision issue that may impact client behavior and potentially their safety while at the facility. The colors are as follows:

Dark Green: Food Allergies

Light Green: Court Ordered

Blue: Medical

Red: Mental Health/Suicide

Orange: Substance Abuse

Pink: Runaway

The program uses colored "sticky dots" that are posted in the client case file on the photo ID sheet. The alerts are also posted on the magnetic display board in the medication room of the facility.

A review of 6 client case files revealed that the application of the Medical/Mental Health alert system was consistent with written policy. All youth had at least 2 of the 7 alerts and one youth had all 7 alerts documented in their case file. Reviewer also confirmed that the corresponding magnetic board consistently matched the same alerts that were listed in the case files.

An interview of the Program Manager and one youth care staff member also confirmed that the system is an effective tool that supports staff communication and utilized in a consistent manner by all staff conducting intakes and placing youth into the system.

There were no exceptions noted during this QI site review.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies were last reviewed on 2/12/13 and were approved and signed by Julie Demar, the Agency's Executive Director.

All staff are trained in CPR, First Aid and in how to handle various emergency medical emergencies. The agency conducts a plethora of simulated emergencies during monthly emergency response drills that are held on each shift. These drills may include the following medical emergencies: snake bite; drowning; broken arm; cut from broken glass; choking on food; medication error or overdose; seizure; and burns.

The plethora of emergency disaster drills (17) are conducted in a consistent manner three times a month (once on each shift) and are documented on a Safe Harbor Emergency Response Simulation that is maintained in a separate binder.

There were three CCC incident reports that were reviewed during this site visit. Two events occurred in October of 2013 and one was in January of 2014, all involving medical emergencies. One of the incidents involved an incorrect medication dosage, another was a slip and fall type of accident and the third incident involved a youth with severe stomach pain (Gastritis) who was transported to the hospital by ambulance. In all three cases the proper response by staff was documented and all of the required notifications were made.

A total of six client case files (3 open, 3 closed) were reviewed for this indicator during the site visit. Of the files reviewed, three of the six had an existing medical condition and/or were taking medications. All three cases had the proper documentation and medical/mental health alerts placed in their files and on the magnetic board in the medication room at the facility.

The program has a knife for life and wire cutters that can be used in suicide emergency situations. These are located in a wall mounted box in the youth care staff office. A first aid kit is also in the staff office, the pantry and in each agency van used to transport clients.

No exceptions were identified during this QI site visit.